

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2015
NAME OF PROVIDER OR SUPPLIER HENDRICKS REGIONAL HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 E MAIN ST DANVILLE, IN 46122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This was a State hospital complaint investigation.</p> <p>Complaint: #IN00153643 Unsubstantiated: Lack of sufficient evidence.</p> <p>Facility Number: 005005</p> <p>Survey Date: 01/20/2015</p> <p>Surveyor: Sandra Nolfi, RN Public Health Nurse Surveyor</p> <p>Hendricks Regional Health is in compliance with 410 IAC 15-1.5-7, Pharmaceutical Services, Hospital Licensure Rules.</p> <p>QA: cloughlin 02/12/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE